2700. FEDERAL REPORTING REQUIREMENTS

Following are instructions and definitions to use in completing the Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, Form HCFA-2082, and the Medicaid Statistical Information System (MSIS.) This hard-copy report form, and the electronic MSIS replacement, are used to report Medicaid cost and utilization data annually to HCFA by States, Territories, and the District of Columbia. Unless otherwise noted, use of the word "State" in the following sections refers to all reporting jurisdictions.

Since 1972, HCFA has required annual submission of Form HCFA-2082 from all States and Territories that operate Medicaid programs under title XIX of the Social Security Act.

The 1980 version of Form HCFA-2082 was a 20 page report, which was expanded to 47 pages in 1984. When the report was expanded, the MSIS was approved as a reporting option. Under this option, a State could submit, if approved, person-specific eligibility and paid claims files on magnetic tape instead of producing and submitting the printed (hard copy) Form HCFA-2082. By offering this option, HCFA could begin to develop a detailed national database of program information capable of supporting a broad range of analysis and reporting applications. Also, participating States could eventually be exempted from preparing and submitting the hard copy Form HCFA-2082 since the database system produces it automatically.

The voluntary nature of the MSIS was modified by the Balanced Budget Act of 1997 (BBA). The BBA requires that States provide for electronic claims data transmission consistent with the MSIS and allows HCFA to specify the format for electronic claims data transmission. States that submit MSIS tapes beginning with the October-December 1998 quarter will be exempt from the hard-copy Form HCFA-2082 requirement for the fiscal year ending September 30, 1999. States opting to delay MSIS participation until the January-March 1999 quarter must submit a hard-copy Form HCFA-2082 for fiscal year 1999. States need not submit the hard-copy Form HCFA-2082 after fiscal year 1999.

The Paperwork Reduction Act of 1995 provides that no person need respond to a Federal collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0345. The time required to complete this information collection is estimated to average 494 hours for hard copy reporting, and 32 hours for MSIS States per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Section 2700.1 addresses the submission of the hard copy Form HCFA-2082. Section 2700.2 addresses the requirements for submitting MSIS tapes.

2700.1 Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services (Form HCFA-2082).--

A. Purpose.--The purpose of Form HCFA-2082 is to provide basic Medicaid data needed for program evaluation, budgeting, planning, and the answering of inquiries at the Federal level. It does not provide all of the information needed for surveillance and administration.

B. Content.--The Form HCFA-2082 provides for reporting summary data of Medicaid eligibles, recipients, services, and medical vendor payments. It is comprised of the following 13 sections, A through M:

Section	Description
A	Recipients of medical care by type of medical service and by maintenance assistance status and basis of eligibility.
B	Amounts of medical vendor payments by type of medical service and by maintenance assistance status and basis of eligibility.
C	Number of Medicaid eligibles by length of eligibility, and maintenance assistance status and basis of eligibility.
D	Eligibles, recipients, and amounts of medical vendor payments by: o Age, race/ethnicity, and sex, and o Age, basis of eligibility, and maintenance assistance status.
E	Recipients, discharges, and days of care for inpatient general hospital by maintenance assistance status and basis of eligibility.
F	Recipients and days of institutional care by maintenance assistance status and basis of eligibility.
G	Recipients of medical care by age, sex, and race/ethnicity, and by type of medical service.
H	Amounts of medical vendor payments by age, sex, and race/ethnicity, and by type of medical service.
I	Recipients of institutional medical care by type of medical service, and by maintenance assistance status and basis of eligibility.
J	Amounts of medical vendor payments for recipients of institutional medical care by type of medical service, and by maintenance assistance status and basis of eligibility.
K	Capitated payments and eligibles by maintenance assistance status and basis of eligibility.
L	Recipients and payments by relationships of payment to title XVIII deductibles and coinsurance and by type of medical service.
M	Recipients and payments by type of service.

C. Reporting Requirements.--Reporting on Form HCFA-2082 by all State agencies administering or supervising the administration of an approved plan for a Federally aided title XIX program is required annually. A report covers the Federal fiscal year which begins October 1 and ends September 30. Copies of the Form HCFA-2082 can be obtained by writing to the address listed below in subsection E.

States that submit MSIS tapes beginning with the October-December 1998 quarter will be exempt from the hard-copy Form HCFA-2082 requirement for the fiscal year ending September 30, 1999. States opting to delay MSIS participation until the January-March 1999 quarter must submit a hard-copy Form HCFA-2082 for fiscal year 1999. After fiscal year 1999, States need not submit the hard-copy Form HCFA-2082.

Report amounts in whole dollars, without cents.

In both the hardcopy Form HCFA-2082 or the magnetic tapes submitted, report the data on the basis of individuals receiving medical care, not cases or families.

D. Effective Date.--Use the revised Form HCFA-2082 effective with the report due for the fiscal year beginning October 1, 1997 and ending September 30, 1998. This hardcopy report is due no later than January 15, 1999 and on the same date each year thereafter.

If you submit data in accordance with the MSIS, and you have been exempted from submitting a hardcopy Form HCFA-2082, submit your data on a quarterly basis according to the schedule and procedures outlined in §2700.2.

E. Submittal Procedure for Hardcopy Form HCFA-2082.--If you submit the hardcopy Form HCFA-2082 report, submit it to:

Health Care Financing Administration
BDMS, OSM, DPS, Medicaid Systems Branch
N2-14-17
7500 Security Blvd.
Baltimore, MD 21244-1850

Send one copy to the appropriate HCFA Regional Office. The report must reach the Medicaid Systems Branch by the close of business January 15 following the end of the Federal fiscal year covered by the report. If January 15 falls on a Saturday, Sunday, or Federal holiday, then the report must reach HCFA by close of business of the next working day.

F. Eligibles To Report.--A Medicaid eligible is someone who:

- Is a member of, or is categorically related to, either a low income family with children (see §1931 of the Act) or an SSI assistance group, or is an individual who qualifies under one of the optional coverage groups;

- Satisfies all of the financial (income and resource) requirements established by the State; and

- Has applied for title XIX assistance and satisfied all of the State's administrative requirements, such as signing over rights to third party medical payments.

Medicaid eligibles may or may not be recipients of maintenance assistance payments. The definitions of maintenance assistance status (MAS) used in Form HCFA-2082 are explained in Appendices A and B.

For Form HCFA-2082, basis of eligibility (BOE) refers to an eligible's categorical relationship to Medicaid. Definitions of the bases of eligibility used in Form HCFA-2082 are explained in Appendices A and B.

Most eligibles are "related" to either a low income family with children (see §1931 of the Act) or SSI as a result of being over 65, or meeting SSI's definition of a blind or disabled individual. In addition, Form HCFA-2082 accepts other title XIX recipients and those who are poverty-related eligibles, including many groups of pregnant women, children, and some groups of Qualified Medicare Beneficiaries (QMBs).

Coverage group refers to all eligibles who have the same maintenance assistance status and basis of eligibility. For example, all eligibles whose maintenance assistance status is medically needy and whose basis for eligibility is disability/blindness are in the same coverage group. Further definition of all current coverage groups with their associated statutory or regulatory citations are contained in Appendix B.

The following rules apply to counting eligibles:

- Individuals who were eligible for title XIX services at any time during the fiscal year are counted.

- Count each eligible only once, even if he or she had more than one period of eligibility during the year or experienced changes in basis of eligibility.

Since the MAS/BOE of any eligible can change during the fiscal year, it is important for you to maintain a consistency from year-to-year of when the count is made. HCFA prefers that the count be based on the last classification of a Medicaid eligible. States that have their Form HCFA-2082 produced by MSIS count their eligible population in this manner. HCFA recognizes, however, that some States have traditionally made their Medicaid eligibility counts based on an eligible's first classification during a fiscal year, and that to change this methodology is burdensome. Therefore, HCFA is allowing two basic choices for an eligible's classification for the hardcopy Form HCFA-2082:

- The last day of the fiscal year. The individual's eligibility on the last day (September 30th) of the fiscal year is used for Form HCFA-2082. If the individual was not eligible on the last day of the fiscal year, then the eligibility used reverts to the classification on the last date during the year on which the individual was eligible.

- The first day of the fiscal year. The individual's eligibility on the first day (October 1) of the fiscal year can be used for Form HCFA-2082. If an individual was not eligible on the first day of the fiscal year, their eligibility is that which was first established during the fiscal year.

Medicaid eligibles are reported in sections C, D, and K.

G. Counting Recipients.--Recipients of Medicaid services are individuals on whose behalf a title XIX payment was made at any time during the reporting period. The service upon which the payment is based need not have occurred during the same reporting period. Payments may have been made for:

- Medical vendor services covered by the State title XIX Plan;

- Title XVIII deductible and coinsurance amounts; or

- Title XIX capitation or payment amounts (other than Medicare buy-in payments).

The classification of recipients follows the same rules used to determine eligibility status stated in subsection F, Eligibles to Report. Additionally, if a recipient was not eligible at any time during the fiscal year, their classification is based on what it was on the last date on which they were eligible.

The sections in which to report recipients are:

1. Report recipients for whom title XIX payments were made directly by the State or through a fiscal agent in sections A, D, E, F, G, I, and M.

2. Report recipients for whom title XVIII deductible and coinsurance amounts were made directly by the State or through a fiscal agent or health insurance plan in sections A, D, G, I, L, and M.

3. Report recipients of services for whom title XIX payments or fees were made to capitated care plans or primary care case management (PCCM) providers and the number of clients in sections A, D, G, I, K, and M.

Recipients of a specific type of service are those for whom at least one payment for that particular service was made. Unduplicated recipient counts are summations of groups of recipients in which no individual can be counted more than once.

H. Counting Expenditures (Payments).--Report expenditures (payments) in whole dollars without cents. The sections in which to report expenditures are:

1. In sections B, D, H, J, and M, report payment of title XIX claims from medical vendors made directly by the State or through a fiscal agent.

2. In sections B, D, H, J, L, and M, report payments of title XVIII deductible and coinsurance amounts made directly by the State or through a fiscal agent or by a health insurance plan.

3. In sections B, D, H, J, K, and M, report payments of title XIX payments or fees made for capitated care plans or primary care case management (PCCM) providers.

4. In sections B, D, H, J, and M, report payments and receipts of amounts adjusting previously paid claims (e.g., refunds, recoupments, voided checks, cost settlements, disallowances) which can be specifically identified by type of service and recipient characteristic and assigned to a particular cell in the report. The net value of all these adjustments, both positive and negative, are added to the sum of payments in that cell as well as the appropriate total lines.

I. Adjustments to Expenditures.--Adjustments are payments and receipts of amounts that adjust previously paid claims. Adjustments include:

- Indian Health Service payments to Medicaid;
- Cost settlements;
- Third party liability recoupments;
- Refunds;
- Voided checks; and
- Other financial transactions that cannot be related to specific provider claims and affect XIX program expenditures.

As indicated in subsection H.4, payment adjustments that can be identified by type of service and eligibility characteristics are to be included in the appropriate detail lines of the report. Adjustments made by canceling a prior payment authorization and authorizing a correct repayment must deduct the canceled service and payment to avoid over counting services and payments.

J. Data to be Excluded from Form HCFA-2082.--Exclude the following data from Form HCFA-2082:

- o Payments made for medical care under the emergency assistance provisions of title IV, Part A;
- o Cost sharing or enrollment fees collected from recipients or a third party; and
- o Administration and training costs.

K. Detailed Instructions.--This section is divided into two major parts: Common Features and Requirements, and Section by Section Descriptions. Use the Section by Section Descriptions in conjunction with the Maintenance Assistance Status and Basis of Eligibility (Appendices A and B), the type of services definitions (Appendix C), and the Racial/Ethnic Classifications (Appendix D).

1. Common Features and Requirements.--The sections of Form HCFA-2082 are in alphabetical order, A through M, which are indicated in the subheading at the top of each page. An exact sequential page-by-page number preceded by the letter "A" is displayed in the top left corner.

Record the full name of the state in the space provided near the upper left hand corner of every page of Form HCFA-2082. Record the federal fiscal year being reported in the space provided in the upper right hand corner of every page.

Each page of the hardcopy Form HCFA-2082 records data in a rectangular array of numbered cells. Cell numbering follows the convention (LL-CC), where LL is the line number and CC is the column number.

Keep in mind that every item of information collected on Form HCFA-2082 is a composite of person-specific characteristics. Thus, every line and column heading represents some way of categorizing the eligibles or recipients.

2. Section by Section Descriptions.--

a. Section A.-- Report, by type of service totals, the number of recipients by maintenance assistance status and their basis of eligibility. Classify individuals under only one category for the entire year. Thus, recipients by category add up to the total of recipients for each column.

Line Descriptions

Line 1.--See Appendices A and B for definitions of basis of eligibility and maintenance assistance status and Appendix C for definitions of type of service.

Line 1, Column 1.--Report the unduplicated total of recipients. A recipient receiving more than one type of service is reported only once in the unduplicated total.

Line 1, Columns 2-20.--Report the numbers of recipients distributed by type of service. Report a recipient in more than one column if more than one type of service was provided.

Lines 2-24--Report, under the applicable headings, the number of recipients receiving each service distributed by maintenance assistance status and basis of their eligibility.

Lines 2-24, Column 1.--Report the unduplicated total of recipients within each maintenance assistance/basis of eligibility category.

Lines 2-24, Columns 2-20.--Report the number of recipients within maintenance assistance/basis of eligibility category.

NOTE: Even if $0 are paid, count one recipient if a claim was processed and determined to be payable.

b. Section B.--Report the amounts of medical vendor payments by maintenance assistance status and basis of eligibility, and by type of medical service. The distribution of payment amounts parallels the distribution of recipients in section A. Report payments under the basis of eligibility/maintenance assistance status of the recipient. Unlike the recipient entries in section A, payment entries are additive to the totals reported for both column and line.

Account for payment adjustments for any reports of vendor payments as defined in section I.

Line Descriptions

Line 1, Column 1.--Report the total of lines 2.a. through 5.e.

Line 1, Columns 2-20.--Report the amounts of payments made to vendors of medical care distributed by type of service. The sum of line 1, columns 2 through 20, must equal the sum of column 1, lines 2.a. through 5.e.

Lines 2-24.--Report under the applicable type of service headings the amounts of medical vendor payments distributed by the maintenance assistance status and basis of eligibility of the recipients.

Lines 2-24, Column 1.--Enter the total of columns 2-20 for these lines.

c. Section C.--Report the unduplicated number of eligibles by length of eligibility, by maintenance assistance status, and basis of eligibility.

Line Descriptions

Line 1.--Report the total unduplicated number of eligibles for a full and partial year. Report the total number of months the partial year eligibles were eligible. Each line in columns 2 and 3 must sum to the total in column 1.

Lines 2-24, Column 1.--Enter the unduplicated number of eligibles by maintenance assistance status and basis of eligibility.

Lines 2-24, Column 2.--Enter the number of eligibles that were eligible for the full 12 months in the reporting year by maintenance assistance and basis of eligibility.

Lines 2-24, Column 3.--Enter the number of eligibles who were eligible for less than 12 months of the reporting year by maintenance assistance and basis of eligibility.

Lines 2-24, Column 4.--Enter the number of months, by maintenance assistance and basis of eligibility, the partial year eligibles reported in column 3 were eligible.

d. Section D.

Sections D.1, D.2, and D.3.--Report in sections D.1 and D.2 the unduplicated number of eligibles and recipients distributed by age, sex, and race/ethnicity. Report in section D.3 the amounts of their medical vendor payments by age, sex, and race/ethnicity. Report age based upon that person's age as of September 30 of the Federal fiscal year of the report.

Line Descriptions, Sections D.1 and D.2

Line 1, Sections D.1 and D.2.--Report the total unduplicated number of recipients or eligibles, distributed by age grouping. See Appendix D for race/ethnicity definitions. Enter totals in the appropriate "Unknown" column if age, sex, or race of any particular recipient or eligible is unknown.

Line 1, Column 1.--Report the unduplicated number of recipients or eligibles, which must equal section A, line 1, column 1, for recipients, or section C, line 1, column 1, for eligibles. This is also the sum of columns 2-11.

Lines 2-25, Columns 2-10.--Report the number of recipients or eligibles distributed by race/ethnicity and age.

Line 1, Column 11.--Report the number of persons of unknown age distributed by race/ethnicity.

Line Descriptions, Section D.3

Lines 1-25, Columns 1-11.--Report the amounts of medical vendor payments by the recipient's age, sex, and race/ethnicity. Follow the same procedures for reporting amounts of payments for recipients with unknown age, sex, or race/ethnicity as used in sections D.1 and D.2.

Sections D.4, D.5, and D.6.--Report in sections D.4 and D.5 the unduplicated number of eligibles and recipients distributed by age, basis of eligibility and maintenance assistance status. Report in section D.6 the amounts of their medical vendor payments by age, basis of eligibility, and maintenance assistance status.

Line Descriptions, Sections D.4 and D.5

Line 1.--Enter the total unduplicated number of recipients or eligibles distributed by age. Report age based upon the person's age as of September 30 of the Federal fiscal year of the report. Enter totals in the appropriate "Unknown" column if the age of any particular recipient or eligible is unknown.

Line 1, Column 1.--Enter the unduplicated number of recipients or eligibles, which must equal section A, line 1, column 1, for recipients, or section C, line 1, column 1 for eligibles. This is the sum of columns 2-11.

Lines 2-24, Columns 2-10.--Enter the number of recipients or eligibles, distributed by the recipient's age on September 30 of the Federal fiscal year of the report and by basis of eligibility and maintenance assistance status.

Line 1, Column 11.--Enter the number of persons of unknown age.

Line Descriptions, Section D.6

Line 1.--Report the total amounts of medical vendor payments by age. Follow the same procedures for reporting amounts of the payments for recipients with unknown age as used in line 1, sections D.4 and D.5.

Lines 2-24.--Report the amounts of medical vendor payments by age and by basis of eligibility and maintenance assistance status. Enter amounts in the appropriate cell of the "Unknown" column if the age of a recipient associated with a vendor payment is unknown.

e. Section E.--Report data on recipients of inpatient general hospital services. Report recipients, discharges, and days of care by basis of eligibility and maintenance assistance status. Exclude recipient counts, discharges, and days of care resulting from title XVIII crossover claims.

A day of care is defined as a day on which a person is confined to a hospital. A day of care is ordinarily counted on the basis of a patient's stay overnight. A stay may be terminated by death or other reason before the first night following admission. Count admission and discharge on the same day as one day.

Count a day of hospital care only if paid for, in whole or in part, by the title XIX program. This includes situations where partial payment is made by the recipient or other third parties (excluding title XVIII funds). If a day of hospital care was paid for entirely with non-Medicaid funds, do not count it.

If payment involves both income of the recipient and State agency funds, include the full count of days paid for, unless that count exceeds any State maximum on days of care for which you pay. For example, a recipient spends six days in the hospital at a daily rate of $60. The total payment of $360 includes $180 from the recipient's income and $180 paid by you under title XIX. For this example, report six days of care. If you have a maximum of five days for which you pay, report only five days.

Column Descriptions

Column 1.--Enter the number of recipients discharged, in total (unduplicated count) and by basis of eligibility and maintenance assistance status. Count each recipient only once regardless of how many paid discharges there were for a recipient during the year.

Column 2.--Enter the total number of discharges from inpatient general hospitals according to basis of eligibility and maintenance assistance status.

Column 3.--Enter the total days of inpatient general hospital services received by all Medicaid recipients.

f. Section F.--Report data on recipients of institutional care by maintenance assistance and basis of eligibility. The institutional care categories for this section are: Inpatient Mental Health Facility Services, Nursing Facility Services, and Intermediate Care Facility-Mentally Retarded (ICF/MR).

Column Descriptions

Section F.1, Column 1.--Enter the total number of unduplicated recipients of inpatient mental health facility services. Inpatient mental health facility services are defined in Appendix C and include the following:

- Mental Hospital Services for the Aged;
- Skilled Nursing and Intermediate Care Services for the Aged in Inpatient Mental Health Facilities; and
- Inpatient Psychiatric Facility Services for Recipients Age 21 and Under.

Count recipients appearing in both column 3 and column 4 in section A.1 only once here. Exclude from Inpatient Mental Health Facility Services recipient counts and days of care resulting from title XVIII crossover claims.

Section F.1, Column 2.--Enter the total number of days reimbursed by title XIX.

Section F.1, Column 3.--Enter the total number of unduplicated recipients of NF services.

Section F.1, Column 4.--Enter the total days of care for recipients of NF services.

Count a day of NF care only if paid for, in whole or in part, by the State agency administering or supervising the title XIX program. If payment involves both personal assets of the recipient and State agency funds, include the full count of days paid.

Unlike columns 1 and 2, include crossover claims in the data reported in columns 3 and 4 on NF services.

If not otherwise known, compute days of NF care on crossover claims by taking the dollar amount on a crossover claim and dividing it by the Medicare daily coinsurance amount for NF patients. The coinsurance amount is usually redetermined each year and is generally equal to 1/8 of the Medicare inpatient hospital deductible.

Section F.2, Column 1.--Enter the total number of unduplicated recipients of ICF services for the mentally retarded.

Section F.2, Column 2.--Enter the total days of care for recipients of ICF services for the mentally retarded.

g. Section G.--Report the unduplicated number of recipients distributed by age grouping, sex, and race/ethnicity and by type of medical service.

Line Descriptions, Sections G.1, G.2, and G.3

Line 1.--Report the total unduplicated number of recipients distributed by age, sex, and race/ethnicity characteristics. Report age based upon the recipient's age as of September 30 of the Federal fiscal year of the report. See Appendix D for race/ethnicity definitions. Enter totals in the appropriate unknown column if the age, sex, or race/ethnicity of any particular recipient is unknown.

Line 1, Column 1.--Enter the unduplicated number of recipients. This must equal the number reported in section A, line 1, column 1.

Line 1, Columns 2-10.--Enter the number of recipients distributed by the recipient's age on September 30 of the Federal fiscal year of the report.

Line 1, Column 11.--Enter the number of recipients of unknown age.

Line 1, Columns 12 and 13.--Enter the number of recipients distributed by the recipient's sex.

Line 1, Column 14.--Enter the number of persons of unknown sex.

Line 1, Columns 15-19.--Enter the number of recipients distributed by the recipient's race/ethnicity.

Line 1, Column 20.--Enter the number of recipients of unknown race/ethnicity.

Lines 2-20.--Enter the number of recipients by age, sex, and race/ethnicity and distributed by type of service. See Appendix C for type of service definitions.

h. Section H.--Report the amounts of medical vendor payments distributed by age group, sex, and race/ethnicity and by type of medical care or service.

Line Descriptions, Sections H.1, H.2, and H.3

Line 1.--Report the total medical vendor payments distributed by age, sex, and race/ethnicity characteristics. Report age based upon the recipient's age as of September 30 of the Federal fiscal year of the report. Enter the totals in the appropriate unknown column if the age or sex of any particular recipient is unknown. Similarly, report in the appropriate unknown column vendor payments for those recipients unable to be classified according to the race/ethnicity definitions given in Appendix D.

Line 1, Column 1.--Enter the total medical vendor payments which must equal section B, line 1, column 1 for total medical vendor payments.

Line 1, Columns 2-10.--Enter the amounts of medical vendor payments by the recipient's age on September 30 of the Federal fiscal year of the report.

Line 1, Column 11.--Enter the amount of payments for recipients of unknown age.

Line 1, Columns 12 and 13.--Enter the amount of medical vendor payments for recipients by sex.

Line 1, Column 14.--Enter the amount of payments for recipients of unknown sex.

Line 1, Columns 15-19.--Enter the amount of medical vendor payments for recipients by race/ethnicity.

Line 1, Column 20.--Enter the amount of payments for recipients of unknown race.

Lines 2-20.--Enter the amount of payments for recipients by age, sex, and race/ethnicity and distributed by type of service. See Appendix C for type of service definitions.

i. Section I.--Report, by type of service, the number of institutionalized recipients by maintenance assistance status and basis of eligibility. An institutionalized individual is any recipient who receives 100 days or more of any combination of nursing facilities (NF) services, ICF services for the mentally retarded, or any inpatient mental health facility services during the reporting period.

Line Descriptions, Sections I.1, I.2, I.3, and I.4

Line 1.--Enter the totals of institutionalized recipients. See Appendices A and B for definitions of basis of eligibility and maintenance assistance status and Appendix C for definitions of types of service.

Line 1, Column 1.--Enter the unduplicated total of recipients. Report a recipient who received more than one type of service only once in the unduplicated total.

Line 1, Columns 2-20.--Enter the number of recipients distributed by type of service. Report a recipient in more than one column if more than one type of service was provided.

j. Section J. --Report the amounts of medical vendor payments by maintenance assistance status and basis of eligibility and by type of medical service for the recipients of institutional care services reported in section I. Unlike the recipient entries in section I, payment entries are additive to the totals reported in each column and line.

Line Descriptions, Sections J.1, J.2, J3, and J4

Line 1.--Enter the total payments for recipients of institutional care. See Appendices A and B for definitions of basis of eligibility and maintenance assistance status and Appendix C for definitions of type of services.

Line 1, Column 1.--Enter the total amount of payments made to vendors of medical care. The sum of line 1, columns 2 through 20, and the sum of column 1, lines 2 through 24 must balance.

Line 1, Columns 2-20.--Enter the total amounts of vendor payments distributed by type of service.

Lines 2-24, Column 1.--Enter the total of columns 2-20 for these lines.

Lines 2-24, Columns 2-20.--Report by type of service the amounts of medical vendor payments distributed by the recipient's maintenance assistance status and basis of eligibility.

k. Section K.--Report, by maintenance assistance status and basis of eligibility, the number of eligibles covered and the amount of payments and fees paid for capitated care services provided by health maintenance organizations (HMO) and health insuring organizations (HIO), prepaid health plans (PHP), and primary care case management (PCCM) plans.

Section Descriptions, Sections K.1 and K.2

Section K.1, Columns 1 and 3.-- Enter the unduplicated number of eligibles by maintenance assistance status and basis of eligibility covered by the different plan types listed.

Section K.1, Columns 2 and 4.--Enter the payments by maintenance assistance status and basis of eligibility attributed to the eligibles in columns 1 and 3 under the appropriate payment column.

Section K.2, Column 1.--Enter the unduplicated number of eligibles by maintenance assistance status and basis of eligibility enrolled in primary care case management plans.

Section K.2, Column 2.--Enter total payments by maintenance assistance status and basis of eligibility attributed to the eligibles in column 1.

Section K.2, Column 3.--Enter the total unduplicated number of eligibles enrolled in one or more plans, as reported in section K.1, columns 1 and 3 or section K.2 column 1, by maintenance assistance status and basis of eligibility for medical care.

l. Section L.--Report, by type of service, information on the number of aged and disabled recipients on whose behalf Medicare (title XVIII) deductibles and coinsurance were paid and on the amounts of the payments. Medicare premiums are not included in this section.

A recipient is considered aged for Medicare if the Medicaid basis of eligibility is aged, or the recipient has an AFDC-related basis of eligibility and is 65 years of age or over.

A recipient is considered disabled for Medicare purposes if the Medicaid basis of eligibility is disabled or blind.

Line Descriptions, Sections L.1 and L.2

The following instructions are identical for section L.1, data on aged recipients, and section L.2, data on disabled recipients.

Line 1.--Enter the unduplicated number of aged or disabled recipients and the total amounts of deductibles and coinsurance paid.

Line 1, Column 1.--Enter the unduplicated number of recipients on whose behalf payments for Medicare deductible and/or coinsurance were made. Since more than one type of service can be given, this total is smaller than the sum of lines 2-20. See below for definitions of deductible and coinsurance.

Line 1, Columns 2 and 3.--Enter the total unduplicated recipient count and associated amount of medical vendor payments for Medicare deductibles paid. A deductible is that portion of applicable medical expenses that must be borne by the insured (or be paid on his/her behalf) before insurance benefits for the calendar year begin. Since more than one type of service can be given, the recipient totals are smaller than the sum of lines 2-20.

Line 1, Columns 4 and 5.--Enter the total unduplicated number of recipients and associated amount of medical vendor payments for Medicare coinsurance. Coinsurance is a joint assumption of risk by the insured and the insurer, whereby each shares on a specific basis, the applicable medical expenses of the insured. The insured's share of coinsurance, like the deductible, may be paid on his/her behalf. For example, under Part B of Medicare, the beneficiary's coinsurance responsibility is a percentage of reasonable and customary expenses greater than the stipulated deductible.

NOTE: Obtain Medicare Part B deductible amounts, coinsurance rates, and applicable requirements yearly from your HCFA Regional Office.

Lines 2-20.--Enter the number of aged or disabled recipients and the corresponding payment amounts reported by type of service.

m. Section M.--Report data on recipients and payments by type of service. See Appendix C for definitions of the expanded service type. For each subsection total, enter the unduplicated number of recipients of the services grouped under that subsection. For example, a recipient of both rural health clinic and FQHC services would be counted only once under the clinic services heading (line 14, column 1).

Line Descriptions.--

Line 1, Columns 1 and 3.--Enter the total number of unduplicated recipients, which must equal total unduplicated recipients under section A, line 1.

Line 1, Columns 2 and 4.--Enter the total payments for all service types. This must equal the sum of the payments for all service types in section B, line 1.

Lines 2 - 21, Column 1 and Lines 1 - 20, Column 3.--Enter the total recipients by type of service.

Lines 2 - 21, Column 2 and Lines 1 - 20, Column 4.--Enter the total payments by type of service.

2700.2 Requirements For the Medicaid Statistical Information System (MSIS).--

Effective for the January-March 1999 quarter, and all subsequent quarters, report Medicaid program data through quarterly submittal of MSIS data tapes. The requirement for a hard-copy HCFA Form-2082 will be eliminated after FY 1999. You must submit tapes containing eligibility and claims information that meet HCFA's MSIS specifications.

A. Purpose.--The Medicaid Statistical Information System (MSIS) creates a national Medicaid data base of person-specific eligibility and claims information. This database is used for analytical research, planning, budgeting, and policy analyses associated with the Medicaid program. MSIS allows for more timely availability of program information and enhances the capacity for program information changes in the Medicaid program.

B. Requirements.--Your MSIS submission must follow the process and meet the systems and data specifications outlined in the documents, "MSIS Participation Guide," and the "Tape Specifications and Data Dictionary," described below.

o MSIS "State Participation Guide." This document outlines the detailed processes you must follow for MSIS implementation.

o MSIS "Tape Specifications and Data Dictionary." This document describes each file type and the data elements within the files. The tape specifications include the coding of data fields, tape formats and record layouts of each required file. The data dictionary section contains definitions of data elements for each file, the field length, and other relevant information.

C. Implementation of MSIS - You must submit eligibility and claims information in electronic format as of January 1, 1999. To comply, you must follow these steps:

Step 1 - Application Process: Complete and submit application form for MSIS implementation as outlined in the "MSIS Participation Guide." Information required includes proposed schedules for file development and testing, appropriate coding crosswalks for both eligibility and service codes, capitated plan ID numbers and names, other State-specific definitions and coding, and descriptions of State-specific factors that may affect the availability and quality of data.

Step 2 - Test Tape/Validation Process: Submit a single quarter's (or a subset) data electronically in order to test the reliability of the electronic process. The data tapes are run through edits, crosswalks are verified, and general data validations are performed at HCFA. You will work in collaboration with HCFA to produce tapes in readable, usable format that pass the data edits.

Step 3 - MSIS Implementation: Upon successful transmission of acceptable tapes, you will submit quarterly eligibility and claims production data tapes as outlined in the "Tape Specifications and Data Dictionary."

While the detailed specifications for the MSIS are contained in the "Tape Specifications and Data Dictionary," there are a number of general principles that apply in preparing the MSIS data tapes.

o While most of the data required for reporting resides in the State's Medicaid Management Information System (MMIS), the reporting requirements are not restricted to data contained in the MMIS. Examples of data that may need to be merged from outside sources include capitation payment records from enrollment systems, eligibility characteristic data from eligibility intake systems, and Medicaid services processed by non-MMIS State departments, such as mental health services. These data represent crucial components of the Medicaid program, and their omission would seriously compromise the utility of the MSIS national database.

o All required data fields must be included on the MSIS files. All data elements in the "Tape Specifications and Data Dictionary," whether or not they are needed for completion of Form HCFA-2082, are required. Some States were permitted to exclude reporting of specific MSIS data fields to facilitate MSIS implementation when the omission of the data would not impact the production of Form HCFA-2082. Because MSIS is shifting to a medium for national analysis of a broad spectrum of issues, all States must report all required MSIS fields. Inconsistent reporting of required fields would limit the utility of MSIS. Any exceptions to comprehensive reporting must be agreed to by HCFA during the application process.

o Some required fields that must be reported include, but are not limited to, Medicaid beneficiary's Social Security Number, inpatient diagnosis codes and procedure codes, inpatient revenue codes, capitated premium payments and fees (including PCCM fees), and recipient plan enrollment data, if available at the State level.

o Eligibility and service crosswalks that realign State-specific categories into standardized Federal reporting must be submitted to facilitate data validation and analysis. Most fields in the MSIS record represent direct extracts from eligibility and claims records that exist in the State's MMIS (and supplemental systems). However, data elements that represent standardized Federal reporting coding include eligibility codes (maintenance assistance status and basis of eligibility) and Federal type-of-service codes. These broad categorical codes are defined in appendices A, B, and C. In order to validate State data and to facilitate use of these coded values, States must supply crosswalks defining the content of each relevant code value. Provide these crosswalks during MSIS application, and update the crosswalks when State coding changes occur.

o In addition to these crosswalks, you must submit State case number definitions, capitated plan identifying numbers and names, and lists of State drug formularies, procedure code modifiers, and specialty codes. This information is necessary to allow interpretation and analysis of many service-related fields.

D. MSIS Data Submission Requirements.--States submit the following Federal fiscal year (FFY) quarterly data files to HCFA:

o File ELIGIBLE.--A file of basic information on all Eligibles. This file includes all eligibles enrolled in the State's Medicaid program regardless of service utilization. It includes information such as birth date, sex, race, days of eligibility, maintenance assistance status, basis of eligibility and plan enrollment.

o File CLAIM-IP.--A file of adjudicated claims for "Inpatient Hospital Care." This file includes all inpatient hospital claims, mental health or general. Information collected includes types of coverage and service, dates of service, diagnosis, procedures, provider identifications, third party and Medicare payments, and Medicaid payment amounts. This file will also contain encounter records for inpatient services that are provided under a capitated plan.

o File CLAIM-LT.--A file of adjudicated claims for "Long Term Institutional Care." This file includes all long-term care claims, whether ICF-MR or general. Information collected includes types of coverage and service, dates of service, diagnoses, provider identifications, third party and Medicare payments, and Medicaid payment amounts. This file will also contain encounter records for long-term care services that are provided under a capitated plan.

o File CLAIM-RX.--A file of all adjudicated claims for drugs. Information collected includes drug codes, date prescribed, drug units, drug days in supply, and prescribing provider. This file will contain encounter records for prescription services that are provided under a capitated plan.

o File CLAIM-OT.--A file of "Other" adjudicated claims that includes all other claims for services not included in CLAIM-IP, CLAIM-LT, or CLAIM-RX. Information collected on this file includes type of service, dates of service, diagnosis, provider identification, third party and Medicare payments, and Medicaid payment amounts. This file will contain premium payments and encounter records for services that are provided under a capitated plan.

Include encounter data in appropriate claims file. Data fields that are not available for encounter records must be documented in the State application.

These files must be submitted no later than 45 days after the end of each Federal fiscal quarter. Under certain conditions, alternate submission schedules can be arranged. However, all departures from already approved submission timetables must be approved in advance by HCFA central office. Submit data files to the following address:

HCFA Data Center/Attn: MSIS Tape Library
Tape Dispatch Area
7500 Security Blvd.
Baltimore, Maryland 21244

E. Quality Assurance Criteria (Edit Checks and Error Tolerances).--After you submit the quarterly MSIS tape files, HCFA will run edits for validation purposes. (All MSIS tape files submitted to HCFA undergo thorough editing and validation testing.) In general, four types of edits are performed:

o Range checks on individual data elements;

o Missing data checks;

o Logical consistency checks among two or more data elements; and

o Distributional checks for reasonableness.

Each element in the MSIS files includes an associated error tolerance. Tolerances vary from element to element and can be as low as 0.1 percent. Lists of error tolerances are presented in the "Tape Specifications and Data Dictionary."

MSIS tape files are considered acceptable only if every data element in the file has an error rate that is below its tolerance. HCFA will notify you of all validation problems after processing the tapes. If you have received notice of validation problems, you have an additional 30 work days from the date of that notification to correct and resubmit the tape(s). As with other MSIS submission deadlines, HCFA exercises flexibility when unusual circumstances arise. However, all deadline changes require prior approval from HCFA central office.

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APPENDIX A

MAINTENANCE ASSISTANCE STATUS AND BASIS OF ELIGIBILITY

MAINTENANCE ASSISTANCE STATUS

Individuals certified eligible for Medicaid are grouped by Maintenance Assistance Status (MAS). Those categories are:

- o Individuals Receiving Cash Assistance or Eligible Under §1931 of the Act;
- o Medically Needy;
- o Poverty-Related Eligibles;
- o Other Eligibles;
- o Section 1115 Demonstration Medicaid Expansion. For MSIS only, report individuals eligible solely due to Medicaid expansions based on a §1115 Demonstration using the code MAS=5; and
- o Child Health Insurance Program (CHIP) Medicaid Expansion. For MSIS only, report these children using the MSIS code MAS=6.

NOTE: For the hard-copy Form HCFA-2082, report children covered by expanded Medicaid coverage under the Child Health Insurance Program as MAS=Other. Report individuals eligible solely due to Medicaid expansions based on §1115 Demonstrations as MAS=Poverty-Related.

Use the following sets of descriptions as definitions of the contents of each MAS category.

Individuals Receiving Cash Assistance, or Eligible Under §1931 of the Act.--These are individuals who are eligible for Medicaid by meeting the specified requirements of one of the following groups. Those reported as individuals receiving cash assistance or eligible under §1931 of the Act are:

- o Individuals qualifying for Medicaid under §1931 of the Act (low-income families with children);
- o Individuals receiving SSI benefits (including participants in the §1619(b) work incentive and those receiving optional State supplementation); and
- o Individuals receiving mandatory State supplements.

Medically Needy.--The medically needy are individuals who are not categorically needy and who have insufficient finances to meet the cost of their medical care and/or expenses. These individuals meet the categorical requirements for Medicaid, but have too much income or resources to qualify for cash assistance. This group also includes individuals who have too much income to qualify under related group or any other eligibility group the State opts to cover.

Some applicants have incomes that exceed the Medically Needy Income Level (MNIL). There are two ways for medically needy individuals with excess income to qualify. First, such individuals may qualify for Medicaid by spending down to a State established level by incurring expenses for necessary medical and remedial care.

An individual who does not qualify for Medicaid under the preceding paragraph may apply an alternative methodology for establishing medically needy eligibility, such as the pay-in spenddown option. If you elect this option, Medicaid applicants may establish eligibility after paying an amount which, when combined with expenses incurred in prior months, will reduce the individual's income below the applicable income limitations. Therefore, the applicant may become eligible after payment of this amount to the State instead of becoming eligible only after having actually incurred expenses.

Poverty Related Eligibles.--This category encompasses all individuals who have become eligible for Medicaid because their family income falls below a specified percentage of the Federal Poverty Level (FPL). These individuals could be eligible either as a result of legislation, including §1902(r)(2) of the Act, or as an expansion population based upon a poverty-related standard authorized under the authority of a section 1115 demonstration project. This heading includes the following mandatory and optional coverage groups:

- All aged, blind, or disabled persons with incomes up to 100% of the FPL who receive full Medicaid coverage;

- All pregnant women and infants with incomes above 133% and not in excess of 185% of the FPL;

- All pregnant women, infants under age 1, and children under age 6 whose family incomes are below 133% of the FPL;

- Mandatory groups of children born after September 30, 1983 whose family incomes are at or below 100% of the FPL;

- Qualified Medicare beneficiaries (QMBs);

- Specified low-income Medicare beneficiaries (SLMBs);

- Qualified disabled working individuals (QDWIs) who are entitled to Medicare Part A;

- Individuals made eligible under the more liberal income and resource disregards of §1902(r)(2) of the Act; and

- Individuals made eligible under the authority of a §1115 waiver (hard-copy HCFA-2082 reporting only; code as MAS=5 for MSIS).

Other Eligibles.--This category contains all other Title XIX groups of individuals, mandatory and optional, who are eligible based on provisions that are not tied to cash assistance, the medically needy program, or a relationship to the FPL. They include, but are not limited to, the following eligibility categories:

- Children receiving title IV-E foster care payments or adoption assistance;

- Individuals who are institutionalized and eligible under a special income level that does not exceed 300% of the SSI Federal benefit rate;

- Individuals who, because of coverage under a home and community based waiver are not in a medical institution, but who would be eligible if they were;

- Individuals who receive hospice care, who would be eligible if in a medical institution;

o Katie Beckett children, which is a group of certain disabled children under age 19 who live at home, but who would be eligible if in a medical institution;

o Families receiving extended benefits described in §1925 of the Act, created by the Family Support Act of 1988;

o Individuals who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX;

o Certain blind or disabled individuals, age 18 or older, who are ineligible for SSI due only to OASDI benefits;

o Title II widow(er)s, who would continue to be eligible for SSI but for their title II benefits, who have not become eligible for Medicare Part A;

o Aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care;

o Individuals who would be eligible for AFDC-related Medicaid, SSI, or an optional State supplement if not in a medical institution;

o Individuals who would be eligible for AFDC-related Medicaid if the State used the broadest allowable AFDC criteria;

o Caretaker relatives who, but for income and resources, would be eligible for AFDC-related Medicaid or SSI;

o Individuals who are eligible for SSI because of requirements that do not apply under title XIX; and

o Children covered by expanded Medicaid coverage under the Child Health Insurance Program (CHIP) (hard-copy HCFA-2082 reporting only; code as MAS=6 for MSIS). (Children covered under CHIP, but not under expanded Medicaid coverage should not be included on the MSIS.)

Section 1115 Demonstration - Medicaid Expansion.--The individuals in this category are eligible solely due to Medicaid expansions based on a Section 1115 Demonstration. For MSIS only, code these individuals as MAS=5.

CHIP (Child Health Insurance Program) - Medicaid Expansion.--The children in this category are covered by the Title XXI Medicaid expansion program, CHIP. For MSIS only, code these individuals as MAS=6.

BASIS OF ELIGIBILITY

All individuals certified eligible for Medicaid must be classified under a basis of eligibility (BOE) for medical care. The following bases of eligibility are used in a matrix format with the maintenance assistance status categories:

o Aged;

o Blind/disabled;

- o Children;
- o Adults;
- o Children and adults based on unemployed parent (UP) deprivation (optional category); and
- o Foster care children.

Definitions for Bases of Eligibility.--

Aged or Blind or Disabled.--Except for States that elect, under §209(b) of the Act, to supply more restrictive criteria, use the definitions established by the Supplemental Security Income (SSI) program to determine whether an individual is aged, or blind or disabled. It is important to note that disabled children are also included in this basis of eligibility.

NOTE: The blind and disabled group have been combined to assist in more efficient reporting.

Children.--These non-disabled individuals must be under age 18 or, at State's option, may be age 18 and attending a secondary or vocational school. The age limit may also be raised to 19, 20, or 21 if the individual otherwise qualifies for Medicaid benefits.

NOTE: Children who are receiving either title IV-E or non-title-IV-E foster care payments or subsidized adoption payments, as well as qualifying for any other child welfare program should not be reported in this category. Report as Foster Care Child below.

Adults.--These are caretaker relatives or pregnant women who qualify for Medicaid and are not aged, blind, or disabled under SSI rules. They may be parents or other blood relatives, step-parents, step-brothers, step-sisters, adoptive parents, grandparents, or any of their spouses.

Unemployed Parent (UP) Children and Adults (Optional Category).--These individuals are children and adults eligible based on an unemployed parent deprivation factor. This category is optional for those States with eligibility codes identifying this group. If this optional category is not used, report these individuals in the appropriate adult and children categories.

Foster Care Children.-- These are children for whom the State makes adoption assistance and/or foster care maintenance payments. This grouping includes both those children who are covered by the provisions of title IV-E and those who are not.

NOTE: Legal aliens who qualify for full Medicaid coverage are reported under the MAS and BOE groupings appropriate for those individuals. While all aliens should be reported on Form HCFA-2082, undocumented aliens do not have satisfactory immigration status and are therefore eligible to receive only emergency Medicaid services under §1903(v) of the Act. These individuals should be reported only under the "Other" grouping. Do not include non-title XIX refugees in your mapping.

APPENDIX B - ELIGIBILITY CROSSWALK

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 Of THE ACT-AGED
MSIS Coding (MAS-1, BOE-1)

	DESCRIPTION	CFR/PL CITATIONS
1	Aged individuals receiving SSI, eligible spouses or persons receiving SSI pending a final determination of disposal of resources exceeding SSI dollar limits; and persons considered to be receiving SSI under §1619(b) of the Act.	42 CFR 435.120 §1619(b) of the Act §1902(a)(10)(A)(I)(II) of the Act PL 99-643, §2
2	Aged individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619 of the Act.	42 CFR 435.121 §1619(b)(3) of the Act; §1902(f) of the Act; PL 99-643, §7
3	Aged individuals receiving mandatory State supplements.	42 CFR 435.130
4	Aged individuals who receive a State supplementary payment (but not SSI) based on need.	42 CFR 435.230, §1902(a)(10)(A)(ii) of the Act.

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT- BLIND/DISABLED
MSIS Coding (MAS-1, BOE-2)

	DESCRIPTION	CFR/PL CITATIONS
1	Blind and/or disabled individuals receiving SSI, eligible spouses or persons receiving SSI pending a final determination of blindness, disability, and/or disposal of resources exceeding SSI dollar limits; and persons considered to be receiving SSI under §1619(b) of the Act.	42 CFR 435.120 §1619(b) of the Act §1902(a)(10)(A)(I)(II) of the Act, PL 99-643, §2
2	Blind and/or disabled individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under §1619.	42 CFR 435.121 §1619(b)(3) of the Act, §1902(f) of the Act, PL 99-643, §7
3	Blind and/or disabled individuals receiving mandatory State supplements.	42 CFR 435.130
4	Blind and/or disabled individuals who receive a State supplementary payment (but not SSI) based upon need.	42 CFR 435.230 §1902(a)(10)(A)(ii)of the Act

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT - CHILDREN
MSIS Coding (MAS-1, BOE-4)

	DESCRIPTION	CFR/PL CITATIONS
1	Low Income Families with Children qualified under §1931 of the Act.	42 CFR 435.110 §1902(a)(10)(A)(I) (I) of the Act §1931 of the Act
2	Children age 18 who are regularly attending a secondary school or the equivalent of vocational or technical training.	42 CFR 435.110 §1902(a)(10)(A)(I) (I)

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 OF THE ACT - ADULTS
MSIS Coding (MAS-1, BOE-5)

	DESCRIPTION	CFR/PL CITATIONS
1	Adults deemed essential for well-being of a recipient [see 45 CFR 233.20(a)(2)(vi)]qualified for Medicaid under §1931 of the Act.	42 CFR 435.110, §1902(a)(10)(A)(I)(I)of the Act §1931 of the Act
2	o Pregnant women who have no other eligible children. o Other Adults in “adult only” units.	42 CFR 435.110, §1902(a)(10)(A)(I)(I)of the Act

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931 -U CHILDREN
MSIS Coding (MAS-1, BOE-6)
(OPTIONAL)

	DESCRIPTION	CFR/PL CITATIONS
1	Unemployed Parent Program -- Cash assistance benefits to low income individuals in two parent families where the principle wage earner is employed fewer than 100 hours a month.	42 CFR 435.110 §1902(a)(10)(A)(I) (I) of the Act §1931 of the Act
2	Children age 18 who are regularly attending a secondary school or the equivalent of vocational or technical training.	42 CFR 435.110 §1902(a)(10)(A)(I) (I) of the Act

MAS/BOE - INDIVIDUALS RECEIVING CASH ASSISTANCE OR ELIGIBLE UNDER SECTION 1931-U ADULTS
MSIS Coding (MAS-1, BOE-7) (OPTIONAL)

	DESCRIPTION	CFR/PL CITATIONS
1	Adults deemed essential for well-being of a recipient (see 45 CFR 233.20(a)(2)(vi))qualified under §1931 of the Act (Low Income Families with Children).	42 CFR 435.110, §1902(a)(10)(A)(I) (I) of the Act, §1931 of the Act
2	o Pregnant women who have no other eligible children. o Other Adults in `adult only' units.	42 CFR 435.110, §1902(a)(10)(A)(I) (I) of the Act

MAS/BOE - MEDICALLY NEEDY - AGED
MSIS Coding (MAS-2, BOE-1)

	DESCRIPTION	CFR/PL CITATIONS
1	Aged individuals who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212, and the same rules apply to medically needy individuals.	42 CFR 435.326
2	Aged	42 CFR 435.320 42 CFR 435.330

MAS/BOE - MEDICALLY NEEDY - BLIND/DISABLED
MSIS Coding (MAS-2, BOE-2)

	DESCRIPTION	CFR/PL CITATIONS
1	Blind and/or disabled individuals who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.	42 CFR 435.326
2	Blind/Disabled	42 CFR 435.322 42 CFR 435.324 42 CFR 435.330
3	Blind and/or disabled individuals who meet all Medicaid requirements except current blindness and/or disability criteria, and have been continuously eligible since 12/73 under the State's requirements.	42 CFR 435.340

MAS/BOE - MEDICALLY NEEDY - CHILDREN
MSIS Coding (MAS-2, BOE-4)

	DESCRIPTION	CFR/PL CITATIONS
1	Individuals under age 18 who, but for income and resources, would be eligible.	§1902(a)(10)(C)(ii) (I) of the Act; PL 97-248, §137
2	Infants under the age of 1 and who were born after 9/30/84 to and living in the household of medically needy women.	§1902(e)(4) of the Act; PL 98-369, §2362
3	Other financially eligible individuals under age 18-21, as specified by the State.	42 CFR 435.308
4	Children who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.	42 CFR 435.326

MAS/BOE - MEDICALLY NEEDY -ADULTS
MSIS Coding (MAS-2, BOE-5)

	DESCRIPTION	CFR/PL CITATIONS
1	Pregnant women.	42 CFR 435.301
2	Caretaker relatives who, but for income and resources, would be eligible.	42 CFR 435.310
3	Adults who would be ineligible if not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.	42 CFR 435.326

MAS/BOE - POVERTY RELATED ELIGIBLES - AGED
MSIS Coding (MAS-3, BOE-1)

	DESCRIPTION	CFR/PL CITATIONS
1	Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income does not exceed 100% of the Federal poverty level, and whose resources do not exceed twice the SSI standard.	§§1902(a)(10)(E)(I) and 1905(p)(1) of the Act; PL 100-203, §4118(p)(8); PL 100-360, §301(a) & (e); PL 100-485, §608(d)(14); PL 100-647, §8434
2	Specified Low-Income Medicare Beneficiaries (SLMBs) who meet all of the eligibility requirements for QMB status, except for the income in excess of the QMB income limit, but not exceeding 120% of the Federal poverty level.	§4501(b) of OBRA 90 as amended in §1902(a)(10)(E) of the Act
3	Qualifying individuals having higher income than allowed for QMBs or SLMBs.	§1902(a)(10)(E)(iv) of the Act

MAS/BOE - POVERTY RELATED ELIGIBLES - BLIND/DISABLED
MSIS Coding (MAS-3, BOE-2)

	DESCRIPTION	CFR/PL CITATIONS
1	Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income does not exceed 100% of the Federal poverty level, and whose resources do not exceed twice the SSI standard.	§§1902(a)(10)(E)(I) and 1905(p)(1) of the Act; PL 100-203, §4118(p)(8); PL 100-360, §301(a) & (e); PL 100-485, §608(d)(14); PL 100-647, §8434
2	Specified Low-Income Medicare Beneficiaries (SLMBs) who meet all of the eligibility requirements for QMB status, except for the income in excess of the QMB income limit, but not exceeding 120% of the Federal poverty level.	§4501(b) of OBRA 90 as amended in §1902(a)(10)(E)(I) of the Act
3	Qualifying individuals having higher income than allowed for QMBs or SLMBs.	§1902(a)(10)(E)(iv) of the Act
4	Qualified Disabled Working Individuals (QDWIs) who are entitled to Medicare Part A.	§§1902(a)(10)(E)(ii) and 1905(s) of the Act

MAS/BOE - POVERTY RELATED ELIGIBLES - CHILDREN
MSIS Coding (MAS-3, BOE-4)

	DESCRIPTION	CFR/PL CITATIONS
1	Infants and children up to age 6 with income at or below 133% of the Federal Poverty Level (FPL).	§§1902(a)(10)(A)(I)(IV) & (VI), 1902(l)(1)(A), (B), & (C) of the Act; PL 100-360, §302(a)(1), PL 100-485, §608(d)(15)
2	Children under age 19 (born after 9/30/83) whose income is at or below 100% of the Federal poverty level within the State's resource requirements.	§1902(a)(10)(A)(I) (VII) of the Act
3	Infants under age 1 whose family income is below 185% of the poverty level and who are within any optional State resource requirements.	§§1902(a)(10)(A)(ii) (IX) and 1902(l)(1)(D) of the Act; PL 99-509, §§9401(a) & (b), PL 100-203, §4101
4	Children made eligible under the more liberal income and resource requirements as authorized under section 1902(r)(2) of the Act when used to disregard income on a poverty-level-related basis.	§1902(r)(2) of the Act

MAS/BOE - POVERTY RELATED ELIGIBLES - ADULTS
MSIS Coding (MAS-3, BOE-5)

	DESCRIPTION	CFR/PL CITATIONS
1	Pregnant women with incomes at or below 133% of the Federal Poverty Level.	§1902(a)(10)(A)(I) (IV) and (VI); §1902(l)(1)(A), (B), & (C) of the Act; PL 100-360, §302(a)(1); PL 100-485, §608(d)(15).
2	Women who are eligible until 60 days after their pregnancy, and whose incomes are below 185% of the FPL and have resources within any optional State resource requirements.	§§1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(D) of the Act, PL 99-509, §§9401(a) & (b); PL 100-203, §4101
3	Caretaker relatives and pregnant women made eligible under more liberal income and resource requirements of section 1902(r)(2) of the Act when used to disregard income on a poverty-level-related basis.	§1902(r)(2) of the Act.

MAS/BOE - OTHER ELIGIBLES - AGED
MSIS Coding (MAS-4, BOE-1)

	DESCRIPTION	CFR/PL CITATIONS
1	Aged individuals who meet more restrictive requirements than SSI and who are either receiving or not receiving SSI; or who qualify under section 1619 of the Act.	42 CFR 435.121 §1619(b)(3) of the Act; §1902(f) of the Act, PL 99-643, §7
2	Aged individuals who are ineligible for optional State supplements or SSI due to requirements that do not apply under title XIX.	42 CFR 435.122
3	Aged essential spouses considered continuously eligible since 12/73; and some spouses who share hospital or nursing facility rooms for 6 months or more.	42 CFR 435.131
4	Institutionalized aged individuals who have been continuously eligible since 12/73 as inpatients or residents of Title XIX facilities.	42 CFR 435.132
5	Aged individuals who would be SSI/SSP eligible except for the 8/72 increase in OASDI benefits.	42 CFR 435.134
6	Aged individuals who would be eligible for SSI but for title II cost-of-living adjustment(s).	42 CFR 435.135
7	Aged aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406
8	Aged individuals who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution.	42.CFR 435.211 §1902(a)(10)(A)(ii) and §1905(a) of the Act
9	Aged individuals who meet income and resource requirements for AFDC, SSI, or an optional State supplement.	42 CFR 435.210 §1902(a)(10)(A)(ii) and §1905 of the Act
10	Aged individuals who have become ineligible and who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212 §1902(e)(2); PL 99-272, §9517; PL 100-203, §4113(d)
11	Aged individuals who, solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217 §1902(a)(10)(A)(ii) (VI); 50 PL 100-13
12	Aged individuals who elect to receive hospice care who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii) (VII) of the Act, PL 99-272, §9505

13	Aged individuals in institutions who are eligible under a special income level specified in Supplement 1 to Attachment 2.6-A of the State's title XIX Plan.	42 CFR 435.236 §1902(a)(10)(A)(ii) of the Act
14	Aged individuals not described in §1902(a)(10)(A)(I) of the Act, with income below the poverty level and resources within State required limits.	§1902(a)(10)(A)(ii)(X), §1902(m)(1) and (m)(3) of the Act; PL 99-509, §§9402(a) & (b)

MAS/BOE - OTHER ELIGIBLES - BLIND/DISABLED
MSIS Coding (MAS-4, BOE-2)

	DESCRIPTION	CFR/PL CITATIONS
1	Blind and/or disabled individuals who meet more restrictive requirements than SSI, including both those receiving and not receiving SSI payments	42 CFR 435.121 §1619(b)(3) of the Act; §1902(f) of the Act PL 99-643, §7
2	Blind and/or disabled individuals who are ineligible for optional State supplements or SSI due to requirements that do not apply under title XIX.	42 CFR 435.122
3	Blind and/or disabled essential spouses considered continuously eligible since 12/73; and some spouses who share hospital or nursing facility rooms for 6 months or more.	42 CFR 435.131
4	Institutionalized blind and/or disabled individuals who have been continuously eligible since 12/73 as inpatients or residents of Title XIX facilities.	42 CFR 435.132
5	Blind and/or disabled individuals who would be SSI/SSP, eligible except for the 8/72 increase in OASDI benefits.	42 CFR 435.134
6	Blind and/or disabled individuals who would be eligible for SSI but for title II cost-of-living adjustment(s).	42 CFR 435.135 §503 PL 94-566
7	Blind and/or disabled aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406
8	Blind and/or disabled individuals who meet all Medicaid requirements except current blindness, or disability criteria, who have been continuously eligible since 12/73 under the State's 12/73 requirements.	42 CFR 435.133

9	Blind and/or disabled individuals, age 18 or older, who became blind or disabled before age 22 and who lost SSI or State supplementary payments eligibility because of an increase in their OASDI (childhood disability) benefits.	§1634(c) of the Act; PL 99-643, §6
10	Blind and/or disabled individuals who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution.	42 CFR 435.211 §§1902(a)(10)(A)(ii) and 1905(a) of the Act
11	Qualified severely impaired blind or disabled individuals under age 65, who, except for earnings, are eligible for SSI.	§§1902(a)(10)(A)(I) (II) and 1905(q) of the Act; PL 99-509, §9404 and §1619(b)(8) of the ACT, PL 99-643, §7
12	Blind and/or disabled individuals who meet income and resource requirements for AFDC, SSI, or an optional State supplement.	42 CFR 435.210 §§1902(a)(10)(A)(ii) and 1905 of the Act
13	Working disabled individuals who buy-in to Medicaid	§1902(a)(10)(A)(ii)(XIII)
14	Blind and/or disabled individuals who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212 §1902(e)(2) of the Act; PL 99-272, §9517; PL 100-203, §4113(d)
15	Blind and/or disabled individuals who, solely because of coverage under a home and community based waiver, are not in a medical institution and who would be eligible if they were.	42 CFR 435.217 §1902(a)(10)(A)(ii) (VI) of the Act; 50 PL 100-13
16	Blind and/or disabled individuals who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii) (VII); PL 99-272, §9505
17	Blind and/or disabled individuals in institutions who are eligible under a special income level specified in Supplement 1 to Attachment 2.6-A of the State's title XIX Plan.	42 CFR 435.231 §1902(a)(10)(A)(ii) of the Act
18	Blind and/or disabled widows and widowers who have lost SSI/SSP benefits but are considered eligible for Medicaid until they become entitled to Medicare Part A.	§1634 of the Act, PL 101-508, §5103
19	Certain Disabled children, 18 or under, who live at home, but who, if in a medical institution, would be eligible for SSI or a State supplemental payment.	42 CFR 435.225; §1902(e)(3) of the Act

20	Disabled individuals not described in §1902(a)(10)(A)(I) of the Act with income below the poverty level and resources within State specified limits.	§1902(a)(10)(A)(ii) (X), §1902(m)(1) and (m)(3) of the Act; PL 99-509, Subsections 9402(a) & (b)

MAS/BOE - OTHER ELIGIBLES - CHILDREN
MSIS Coding (MAS-4, BOE-4)

	DESCRIPTION	CFR/PL CITATIONS
1	Children of families receiving up to 12 months of extended Medicaid benefits (for those eligible after 4/1/90).	§1925 of the Act, PL 100-485, §303
2	"Qualified children" under age 19 born after 9/30/83 or at an earlier date at State option, who meet the State's AFDC income and resource requirements.	§§1902(a)(10)(A)(I)(III) and 1905(n) of the Act; PL 98-369, §2361; PL 99-272, §9511; PL 100-203, §4101
3	Children of individuals who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX.	42 CFR 435.113
4	Children of individuals who would be eligible for Medicaid under section 1931 of the Act (Low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase and were entitled to OASDI and received cash assistance in 8/72.	42 CFR 435.114
5	Children whose mothers were eligible for Medicaid at the time of childbirth, and are deemed eligible for one year from birth as long as the mother remained eligible, or would have if pregnant, and the child remains in the same household as the mother.	42 CFR 435.117 §1902(e)(4) of the Act; PL 98-369, §2362
6	Children of aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406
7	Children who meet income and resource requirements for AFDC, SSI, or an optional State supplement	42 CFR 435.210 §1902(a)(10)(A)(ii) and §1905 of the Act
8	Children who would be eligible for AFDC, SSI, or an optional State supplement if not in a medical institution.	42 CFR 435.211 §1902(a)(10)(A)(ii) and §1905(a) of the Act
9	Children who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212 §1902(e)(2) of the Act; PL 99-272, §9517; PL 100-203, §4113(d)

10	Children of individuals who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii)(VII); PL 99-272, §9505
11	Children who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service.	42 CFR 435.220
12	Children of individuals who would be eligible for AFDC if the State used the broadest allowable AFDC criteria.	42 CFR 435.223 §§1902(a)(10)(A)(ii) and 1905(a) of the Act
13	Children who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217 §1902(a)(10)(A)(ii)(VI) of the Act.
14	Children not described in §1902(a)(10)(A)(I) of the Act, "Ribikoff Kids", who meet AFDC income and resource requirements, and are under a State-established age (18-21).	§§1902(a)(10)(A)(ii) and 1905(a)(I) of the Act, PL 97-248, §137

MAS/BOE - OTHER ELIGIBLES - ADULTS
MSIS Coding (MAS-4, BOE-5)

	DESCRIPTION	CFR/PL CITATIONS
1	Families receiving up to 12 months of extended Medicaid benefits (if eligible on or after 4/1/90).	§1925 of the Act, PL 100-485, §303
2	Qualified pregnant women whose pregnancies have been medically verified and who meet the State's AFDC income and resource requirements.	§§1902(a)(10)(A)(I)(III) and 1905(n) of the Act; PL 98-369, §2361; PL 99-272, §9511, PL 100-203 §4101
3	Adults who are ineligible for AFDC-related Medicaid because of requirements that do not apply under title XIX.	42 CFR 435.113
4	Adults who would be eligible for Medicaid under §1931 of the Act (Low income families with children) except for the 7/1/72 (PL 92-325) OASDI increase; and were entitled to OASDI and received cash assistance in 8/72.	42 CFR 435.114
5	Women who were eligible while pregnant, and are eligible for family planning and pregnancy related services until the end of the month in which the 60th day occurs after the pregnancy	§1902(e)(5) of the Act; PL 98-369; PL 100-203, §4101; PL 100-360, §302(e)
6	Adult aliens who are not lawful, permanent residents or who do not have PRUCOL status, but who are otherwise qualified, and who require emergency care.	PL 99-509, §9406

7	Adults who meet the income and resource requirements for AFDC, SSI, or an optional State Supplement.	42 CFR 435.210 §§1902(a)(10)(A)(ii) and 1905 of the Act
8	Adults who would be eligible for AFDC, SSI, or an optional State Supplement if not in a medical institution.	42 CFR 435.211 §§1902(a)(10)(A)(ii) and 1905(a) of the Act
9	Adults who have become ineligible who are enrolled in a qualified HMO or "§1903(m)(2)(G) entity" that has a risk contract.	42 CFR 435.212 §1902(e)(2)(A) of the Act; PL 99-272, §9517, PL 100-203, §4113(d)
10	Adults who solely because of coverage under a home and community based waiver, are not in a medical institution, but who would be eligible if they were.	42 CFR 435.217, §1902(a)(10)(A)(ii)(VI) of the Act.
11	Adults who elect to receive hospice care, and who would be eligible if in a medical institution.	§1902(a)(10)(A)(ii) (VII); PL 99-272, §9505
12	Adults who would be eligible for AFDC if work-related child care costs were paid from earnings rather than received as a State service.	42 CFR 435.220
13	Pregnant women who have been granted presumptive eligibility.	§§1902(a)(47) and 1920 of the Act; PL 99-509, §9407
14	Adults who would be eligible for AFDC if the State used the broadest allowable AFDC criteria.	42 CFR 435.223 §§1902(a)(10)(A)(ii) and 1905(a) of the Act

MAS/BOE - OTHER ELIGIBLES - FOSTER CARE CHILDREN
MSIS Coding (MAS-4, BOE-8)

	DESCRIPTION	CFR/PL CITATIONS
1	Children for whom the State makes adoption assistance or foster care maintenance payments under Title IV-E.	42 CFR 435.145 §1902(a)(10)(A)(i)(I) of the Act
2	Children with special needs covered by State foster care payments or under a State adoption assistance agreement which does not involve Title IV-E.	§1902(a)(10)(A)(ii) (VIII) of the Act; PL 99-272, §9529

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION (Code as POVERTY ELIGIBLES - AGED for hard-copy HCFA-2082 reporting)
MSIS Coding (MAS=5, BOE=1)

	DESCRIPTION	CFR/PL CITATION
1	Aged individuals made eligible under the authority of a Section 1115 waiver due to poverty-level related eligibility expansions.	§1115(a)(1), (a)(2) & (b)(1) of the Act; §1902(a)(10) and §1903(m) of the Act

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION (Code as POVERTY ELIGIBLES - BLIND/DISABLED for hard-copy HCFA-2082 reporting)
MSIS Coding (MAS=5, BOE=2)

	DESCRIPTION	CFR/PL CITATION
1	Blind and/or disabled individuals made eligible under the authority of a Section 1115 waiver due to poverty-level-related eligibility	§1115(a)(1), (a)(2) & (b)(1) of the Act; §1902(a)(10) and §1903(m) of the Act

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION (Code as POVERTY ELIGIBLES - CHILDREN for hard-copy HCFA-2082 reporting)
MSIS Coding (MAS=5, BOE=4)

	DESCRIPTION	CFR/PL CITATION
1	Children made eligible under the authority of a §1115 waiver due to poverty-level-related eligibility expansions.	§1115(a)(1), (a)(2) & (b)(1) of the Act; §1902(a)(10) and §1903(m) of the Act

MAS/BOE - SECTION 1115 DEMONSTRATION MEDICAID EXPANSION (Code as POVERTY ELIGIBLES - ADULTS for hard-copy HCFA-2082 reporting)
MSIS Coding (MAS=5, BOE=5)

	DESCRIPTION	CFR/PL CITATION
1	Caretaker relatives and pregnant women made eligible under the authority of at section 1115 waiver due to poverty-level-related eligibility expansions.	§1115(a)(1) and (a)(2) of the Act; §1902(a)(10) and §1903(m).

MAS/BOE - CHIP MEDICAID EXPANSION (Code as OTHER ELIGIBLES - CHILDREN for hard-copy HCFA-2082 reporting)
MSIS Coding (MAS=6, BOE=4)

	DESCRIPTION	CFR/PL CITATION
1	Children covered by expanded Medicaid coverage under the Child Health Insurance Program (CHIP)	§1902(a)(10)(A)(ii)(XIV) of the Act

APPENDIX C

DEFINITIONS OF TYPES OF SERVICE AND MSIS PROGRAM TYPE CODING

The following definitions are adaptations of those given in the Code of Federal Regulations (CFR). These definitions, although abbreviated, are intended to facilitate the classification of medical care and services for reporting purposes. They do not modify any requirements of the Act or supersede in any way the definitions included in the CFR.

Effective FY 1999, services provided under Family Planning, the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), Indian Health Facilities, and Home-and-Community-Based Waiver programs will be coded according to the types of services listed below. Specific programs with which these services are associated will be identified using the program type coding as defined in Appendix C.1.

NOTE: For hard-copy 2082 submissions only, continue to report program types listed in Appendix C.1 as types of service.

1. Unduplicated Total.--Report the unduplicated total of recipients by maintenance assistance status (MAS) and by basis of eligibility (BOE). A recipient receiving more than one type of service is reported only once in the unduplicated total.

2. Inpatient Hospital Services (MSIS Code=01)(See 42 CFR 440.10).--These are services that are:

o Ordinarily furnished in a hospital for the care and treatment of inpatients;

o Furnished under the direction of a physician or dentist (except in the case of nurse-midwife services per 42 CFR 440.165); and

o Furnished in an institution that:

- Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

- Is licensed or formally approved as a hospital by an officially designated authority for State standard setting;

- Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services per 42 CFR 440.165); and

- Has in effect a utilization review plan applicable to all Medicaid patients that meet the requirements in 42 CFR 482.30 unless a waiver has been granted by the Secretary of Health and Human Services.

Inpatient hospital services do not include nursing facility services furnished by a hospital with swing-bed approval. However, include services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separated from the general hospital.

3. Mental Health Facility Services (See 42 CFR 440.140, 440.160, and 435.1009).--An institution for mental diseases is a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care of individuals with mental diseases, including medical care, nursing care, and related services. Report totals for services defined under 3a and 3b.

o Inpatient Psychiatric Facility Services for Individuals Under Age 21 (MSIS Code=04) (See 42 CFR 440.160 and 441.150(ff)).--These are services that:

- Are provided under the direction of a physician;

- Are provided in a psychiatric facility or inpatient program accredited by the Joint Commission on the Accreditation of Hospitals; and

- Meet the requirements set forth in 42 CFR Part 441, Subpart D (inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs).

o Other Mental Health Facility Services (Individuals Age 65 or Older) (MSIS Code=02) (See 42 CFR 440.140(a) and Part 441, Subpart C).--These are services provided under the direction of a physician for the care and treatment of recipients in an institution for mental diseases that meets the requirements specified in 42 CFR 440.140(a).

4. Nursing Facilities (NF) Services(MSIS Code=07)(See 42 CFR 440.40 and 440.155).--These are services provided in an institution (or a distinct part of an institution) that:

o Is primarily engaged in providing to residents:

- Skilled nursing care and related services for residents who require medical or nursing care;

- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

- On a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; and

o Meet the requirements for a nursing facility described in subsections 1919(b), (c), and (d) of the Act regarding:

- Requirements relating to provision of services;

- Requirements relating to residents' rights; and

- Requirements relating to administration and other matters.

NOTE: ICF Services - All Other--This is combined with nursing facility services.

5. ICF Services for the Mentally Retarded(MSIS Code=05)(See 42 CFR 440.150 and Part 483 of Subpart I).--These are services provided in an institution for mentally retarded persons or persons with related conditions if the:

o Primary purpose of the institution is to provide health or rehabilitative services to such individuals;

o Institution meets the requirements at 42 CFR 442, Subpart C (certification of ICF/MR); and

o The mentally retarded recipients for whom payment is requested are receiving active treatment as defined at 42 CFR 483.440(a).

6. Physicians' Services (MSIS Code=08)(See 42 CFR 440.50).--Whether furnished in a physician's office, a recipient's home, a hospital, a NF, or elsewhere, these are services provided:

o Within the scope of practice of medicine or osteopathy as defined by State law; and

o By, or under, the personal supervision of an individual licensed under State law to practice medicine or osteopathy, or dental medicine or dental surgery if State law allows such services to be provided by either a physician or dentist.

7. Outpatient Hospital Services (MSIS Code=11)(See 42 CFR 440.20).--These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished:

o To outpatients;

o Except in the case of nurse-midwife services (see 42 CFR 440.165), under the direction of a physician or dentist; and

o By an institution that:

- Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and

- Except in the case of medical supervision of nurse midwife services (see 42 CFR 440.165), meets the requirements for participation in Medicare as a hospital.

8. Prescribed Drugs (MSIS Code=16)(See 42 CFR 440.120(a)).--These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance that are:

o Prescribed by a physician or other licensed practitioner within the scope of professional practice as defined and limited by Federal and State law;

o Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

o Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

9. Dental Services (MSIS Code=09)(See 42 CFR 440.100).--These are diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of:

o The teeth and associated structures of the oral cavity; and

o Disease, injury, or an impairment that may affect the oral or general health of the recipient.

A dentist is an individual licensed to practice dentistry or dental surgery. Dental services include dental screening and dental clinic services.

Dental services do not include services provided as part of inpatient hospital, outpatient hospital, non-dental clinic, or laboratory services and billed by the hospital, non-dental clinic, or laboratory or services that meet the requirements of 42 CFR 440.50(b) (i.e., are provided by a dentist but may be provided by either a dentist or physician under State law).

NOTE: Report dentures under Other Care. Dentures are artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.

10. Other Licensed Practitioners' Services (MSIS Code=10) (See 42 CFR 440.60).--These are medical or remedial care services, other than physician services or services of a dentist, provided by licensed practitioners within the scope of practice as defined under State law. The category "Other Licensed Practitioners' Services" is different than the "Other Care" category. Examples of other practitioners (if covered under State law) are:

- o Chiropractors;
- o Podiatrists;
- o Psychologists; and
- o Optometrists.

Other Licensed Practitioners' Services include hearing aids and eyeglasses only if they are billed directly by the professional practitioner. If billed by a physician, they are reported as Physicians' Services. Otherwise, report them under Other Care.

Other Licensed Practitioners' Services do not include prosthetic devices billed by physicians, laboratory or X-ray services provided by other practitioners, or services of other practitioners that are included in inpatient or outpatient hospital bills. These services are counted under the related type of service as appropriate. Devices billed by providers not included under the listed types of service are counted under Other Care.

Report Other Licensed Practitioners' Services that are billed by a hospital as inpatient or outpatient services, as appropriate.

Speech therapists, audiologists, opticians, physical therapists, and occupational therapists are not included within Other Licensed Practitioners' Services.

Chiropractors' services include only services that are provided by a chiropractor (who is licensed by the State) and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

11. Clinic Services (MSIS Code=12) (See 42 CFR 440.90).--Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are provided:

- o To outpatients;
- o By a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients including services furnished outside the clinic by clinic personnel to individuals without a fixed home or mailing address. For reporting purposes, consider a group of physicians who share, only for mutual convenience, space, services of support staff, etc., as

physicians, rather than a clinic, even though they practice under the name of the clinic; and

o Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under, the direction of a physician.

NOTE: Place dental clinic services under dental services. Report any services not included above under other care. A clinic staff may include practitioners with different specialities.

12. Laboratory and X-Ray Services(MSIS Code=15) (See 42 CFR 440.30).--These are professional or technical laboratory and radiological services that are:

o Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law or ordered and billed by a physician but provided by referral laboratory;

o Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and

o Provided by a laboratory that meets the requirements for participation in Medicare.

X-ray services provided by dentists are reported under dental services.

13. Sterilizations (MSIS Code=24)(See 42 CFR 441, Subpart F).--These are medical procedures, treatment or operations for the purpose of rendering an individual permanently incapable of reproducing.

14. Home Health Services (MSIS Code=13)(See 42 CFR 440.70).--These are services provided at the patient's place of residence, in compliance with a physician's written plan of care that the physician reviews every 60 days. The following items and services are mandatory.

o Nursing services, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency (a public or private agency or organization, or part of any agency or organization, that meets the requirements for participation in Medicare). If there is no agency in the area, a registered nurse who:

- Is licensed to practice in the State;

- Receives written orders from the patient's physician;

- Documents the care and services provided;

- Has had orientation to acceptable clinical and administrative record keeping from a health department nurse;

o Home health aide services provided by a home health agency; and

o Medical supplies, equipment, and appliances suitable for use in the home.

The following therapy services are optional: physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide these medical rehabilitation services (see 42 CFR 441.15).

Place of residence is normally interpreted to mean the patient's home and does not apply to hospitals or NFs. Services received in a NF that are different from those normally provided as part of the institution's care may qualify as home health services. For example, a registered nurse may provide short-term care for a recipient in a NF during an acute illness to avoid the recipient's transfer to another NF.

15. Personal Support Services.--Report total unduplicated recipients and payments for services defined in 15a through 15i.

a. Personal Care Services (MSIS Code=30)(See 42 CFR 440.167).--These are services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

- Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; and

- Provided by an individual who is qualified to provide such services and who is not a member of the individual's family.

b. Targeted Case Management Services (MSIS Code=31)(See §1915(g)(2) of the Act).--These are services that are furnished to individuals eligible under the plan to gain access to needed medical, social, educational, and other services. The agency may make available case management services to:

- Specific geographic areas within a State, without regard to statewide requirement in 42 CFR 431.50; and

- Specific groups of individuals eligible for Medicaid, without regard to the comparability requirements in 42 CFR 440.240.

The agency must permit individuals to freely choose any qualified Medicaid provider except when obtaining case management services in accordance with 42 CFR 431.51.

c. Rehabilitative Services (MSIS Code=33)(See 42 CFR 440.130(d)).--These include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

d. Physical Therapy, Occupational Therapy, and Services For Individuals With Speech, Hearing, and Language Disorders (MSIS Code=34)(See 42 CFR 440.110).--These are services prescribed by a physician or other licensed practitioner within the scope of his or her practice under State law and provided to a recipient by, or under the direction of, a qualified physical therapist, occupational therapist, speech pathologist, or audiologist. It includes any necessary supplies and equipment.

e. Hospice Services (MSIS Code=35)(See 42 CFR 418.202).--Whether received in a hospice facility or elsewhere, these are services that are:

o Furnished to a terminally ill individual, as defined in 42 CFR 418.3;

o Furnished by a hospice, as defined in 42 CFR 418.3, that meets the requirements for participation in Medicare specified in 42 CFR 418, Subpart C or by others under an arrangement made by a hospice program that meets those requirements and is a participating Medicaid provider; and

o Furnished under a written plan that is established and periodically reviewed by:

- The attending physician;

- The medical director or physician designee of the program, as described in 42 CFR 418.54; and

- The interdisciplinary group described in 42 CFR 418.68.

f. Nurse Midwife (MSIS Code=36)(See 42 CFR 440.165 and 441.21).--These are services that are concerned with management and the care of mothers and newborns throughout the maternity cycle and are furnished within the scope of practice authorized by State law or regulation.

g. Nurse Practitioner (MSIS Code=37)(See 42 CFR 440.166 and 441.22).--These are services furnished by a registered professional nurse who meets State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses.

h. Private Duty Nursing (MSIS Code=38)(See 42 CFR 440.80).--When covered in the State plan, these are services of registered nurses or licensed practical nurses provided under direction of a physician to recipients in their own homes, hospitals or nursing facilities (as specified by the State).

i. Religious Non-Medical Health Care Institutions (MSIS Code=39)(See 42 CFR 440.170(b)(c)).--These are non-medical health care services equivalent to a hospital or extended care level of care provided in facilities that meet the requirements of §1861 (ss) (1) of the Act.

16. Other Care (See 42 CFR 440.120(b), (c), and (d), and 440.170(a)).--Report total unduplicated recipients and payments for services defined in 16a, 16b, and 16c. Such services do not meet the definition of, and are not classified under, any of the previously described categories.

a. Transportation (MSIS Code=26)(See 42 CFR 440.170(a)).--Report totals for services provided under this title to include transportation and other related travel services determined necessary by you to secure medical examinations and treatment for a recipient.

NOTE: Transportation, as defined above, is furnished only by a provider to whom a direct vendor payment can appropriately be made. If other arrangements are made to assure transportation under 42 CFR 431.53, Federal financial participation (FFP) is available as an administrative cost.

b. Abortions (MSIS Code=25)(See 42 CFR 441, Subpart E).--In accordance with the terms of the DHHS Appropriations Bill and 42 CFR 441, Subpart E, FFP is available for abortions:

o When a physician has certified in writing to the Medicaid agency that the woman suffers from a physical disorder, injury, or illness so that the woman is in danger of death if an abortion is not performed; or

o When the abortion is performed to terminate a pregnancy resulting from an act of rape of incest. FFP is not available for an abortion under any other circumstances.

c. Other Services (MSIS Code=19).--These services do not meet the definitions of any of the previously described service categories. They may include, but are not limited to:

o Prosthetic devices (see 42 CFR 440.120(c)) which are replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice as defined by State law to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunctions; or
- Support a weak or deformed portion of the body.

o Dentures and eyeglasses (see 42 CFR 440.120(b) and (d)). Dentures mean artificial structures made by, or under the direction of, a dentist to replace a full or partial set of teeth. Eyeglasses mean lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optician. It includes optician fees for services.

17. Capitated Care (See 42 CFR Part 434).--This includes enrollees and capitated payments for the plan types defined in 19 a and b below. Report unduplicated enrolled eligibles and payments for 19 a and b.

a. Health Maintenance Organization (HMO) and Health Insuring Organization (HIO)(MSIS Code=20).--These include plans contracted to provide capitated comprehensive services. An HMO is a public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and is federally qualified or State-plan defined. An HIO is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

b. Prepaid Health Plans (PHP)(MSIS Code=21).--These include plans that are contracted to provide less than comprehensive services. Under a non-risk or risk arrangement, the State may contract with (but not limited to these entities) a physician, physician group, or clinic for a limited range of services under capitation. A PHP is an entity that provides a non-comprehensive set of services on either capitated risk or non-risk basis or the entity provides comprehensive services on a non-risk basis.

NOTE: Include dental, mental health, and other plans covering limited services under PHP.

18. Primary Care Case Management (PCCM) (MSIS Code=22)(See §1915(b)(1) of the Act).--The State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee. Report these recipients and associated PCCM fees in this section.

NOTE: Where the fee includes services beyond case management, report the enrollees and fees under prepaid health plans (17b).

APPENDIX C.1
DEFINITIONS OF PROGRAM TYPES

The following definitions describe special Medicaid programs that are coded independently of type of service for MSIS purposes. These programs cover bands of services that may cut across many types of service.

A. Program Type 1. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (See 42 CFR 440.40(b)).--This includes either general health screening services and vision, dental, and hearing services furnished to Medicaid eligibles under age 21 to fulfill the requirements of the EPSDT program or services rendered based on referrals from EPSDT visits. The Act specifies two sets of EPSDT screenings:

o Periodic screenings, which are provided at distinct intervals determined by the State, and which must include the following services:

- A comprehensive health and developmental history assessment (including assessment of both physical and mental health development);

- A comprehensive unclothed physical exam;

- Appropriate immunizations according to the Advisory Committee on Immunization Practices schedule;

- Laboratory tests (including blood lead level assessment);

- Health education (including anticipatory guidance); and

o Interperiodic screenings, which are provided when medically necessary to determine the existence of suspected physical or mental illness or conditions.

B. Program Type 2. Family Planning (See 42 CFR 440.40(c)).--Only items and procedures clearly provided or performed for family planning purposes and matched at the 90 percent FFP rate should be included as Family Planning. Services covered under this program include, but are not limited to:

o Counseling and patient education and treatment furnished by medical professionals in accordance with State law;

o Laboratory and X-ray services;

o Medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception;

o Natural family planning methods; and

o Diagnosis and treatment for infertility.

NOTE: HCFA's Revised Financial Management Review Guide for Family Planning Services describes items and procedures eligible for the enhanced match as family planning services.

C. Program Type 3. Rural Health Clinics (RHC)(See 42 CFR 440.20(b)).--These include services (as allowed by State law) furnished by a rural health clinic that has been certified in accordance with the conditions of 42 CFR Part 491 (certification of certain health facilities). Services performed in RHCs include, but are not limited to:

o Services furnished by a physician within the scope of his or her profession as defined by State law. The physician performs these services in or away from the clinic and has an agreement with the clinic providing that he or she will be paid by the clinic for these services;

o Services furnished by a physician assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner (as defined in 42 CFR 405.2401 and 491.2) if the services are furnished in accordance with the requirements specified in 42 CFR 405.2412(a);

o Services and supplies provided in conjunction with professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. (See 42 CFR 405.2413 and 405.2415 for the criteria determining whether services and supplies are included here.); or

o Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:

- The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies (see 42 CFR 405.2417);

- The services are furnished by a registered nurse or licensed practical or vocational nurse employed, or otherwise compensated for the services, by the clinic;

- The services are furnished under a written plan of treatment that is either established and reviewed at least every 60 days by a supervising physician of the clinic, or that is established by a physician, physician's assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

- The services are furnished to a homebound patient. For purposes of visiting nurse services, a homebound recipient means one who is permanently or temporarily confined to a place of residence because of a medical or health condition and leaves the place of residence infrequently. For this purpose, a place of residence does not include a hospital or nursing facility.

D. Program Type 4. Federally Qualified Health Center (FQHC) (See §1905(a)(2)(A) of the Act).--FQHCs are facilities or programs more commonly known as community health centers, migrant health centers, and health care for the homeless programs. A facility or program qualifies as a FQHC providing services covered under Medicaid if:

o They receive grants under §§329, 330, or 340 of the Public Health Service Act (PHS);

o The Health Resources and Services Administration, PHS, certifies the center as meeting FQHC requirements; or

o The Secretary determines that the center qualifies through waiver of the requirements.

Services performed in FHQCs are defined as the same for services provided by rural health clinics. They may include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as are otherwise covered if furnished by a physician, or as incident to a physician's services. In certain cases, services to a homebound Medicaid patient may be provided. Any other ambulatory service included in the State's Medicaid plan is considered covered by a FQHC program if the center offers it.

E. Program Type 5. Indian Health Services (See §1911 of the Act) (See 42 CFR 431.110).- These are services provided by the Indian Health Service (IHS), an agency charged with providing the primary source of health care for American Indian and Alaska Native people who are members of federally recognized tribes and organizations. A State plan must provide that an IHS facility, meeting State plan requirements for Medicaid participants, must be accepted as a Medicaid provider on the same basis as any other qualified provider.

F. Program Type 6. Home and Community-Based Care for Functionally Disabled Elderly (See §1929 of the Act) and for Individuals Age 65 and Older(MSIS (See 42 CFR 441, Subpart H).--This program is for §1915(d) recipients of home and community-based services for individuals age 65 or older. This is an option within the Medicaid program to provide home and community-based care to functionally disabled individuals age 65 or older who are otherwise eligible for Medicaid or for non-disabled elderly individuals.

G. Program Type 7. Home and Community-Based Waivers (See §1915(c) of the Act and 42 CFR 440.180).--This program includes services furnished by a waiver approved under the provisions in 42 CFR Part 441, Subpart G (home and community-based services; waiver requirements).

SERVICE HIERARCHY

Experience has demonstrated there can be instances when more than one service area category could be applicable for a provided service. The following rules apply to these instances:

- The specific service categories of sterilizations and abortions take precedence over provider categories, such as inpatient hospital or outpatient hospital;

- Services of a physician employed by a clinic are reported under clinic services if the clinic is the billing entity. X-rays processed by the clinic in the course of treatment, however, are reported under X-ray services; and

- Services of a registered nurse attending a resident in a NF are reported (if they qualified under the coverage rules) under home health services if they were not billed as part of the NF bill. (See section M.)

APPENDIX D

RACIAL/ETHNIC CLASSIFICATIONS

The following classifications are not to be interpreted as scientific or anthropological in nature, nor are they to be used to determine eligibility for the Medicaid program. They have been developed and correspond directly to requirements established by the executive branch and the Congress.

DEFINITIONS

The changes indicated below take effect for MSIS coding only, and will not be reported for remaining submittals of Form HCFA-2082.

White - A person having origins in any of the original peoples of Europe, North Africa, or the middle East.

Black or African American - A person having origins in any of the black racial groups of Africa.

American Indian or Alaskan Native - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Hispanic or Latino - A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Use the category that most closely reflects the individual's recognition in his community for reporting on persons who are of mixed racial and/or ethnic origins.

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